

routine examination.

Women with concomitant infections, such as trichomoniasis and gonorrhoea, were excluded and the remaining 195 women with chlamydial infection were treated with minocycline 50 mg twice daily for seven days and followed for up to six months after completing treatment, cervical culture for *C trachomatis* being repeated on each occasion. Of the 195 patients entered into the study, 18 failed to keep their first follow up appointment and four did not complete the course of treatment; thus 173 patients were available for evaluation. The results of treatment are shown in the table.

TABLE Results of cultures of cervical material for *Chlamydia trachomatis* after treatment for one week with minocycline 50 mg twice daily (number of possible reinfections in parentheses)

Time after completion of treatment	No examined	No yielding <i>C trachomatis</i>
0- 7 days	162	0
8-14 days	112	1
15-21 days	42	2 (2)
22-28 days	15	0
1- 2 months	31	1 (1)
2- 4 months	18	1 (1)
4- 6 months	14	2 (2)

Early reisolation of *C trachomatis*, 8-14 days after completion of treatment, was noted in only one of 112 patients. Late reisolation was rare and was confined to those who had resumed intercourse, making reinfection a possibility. Side effects occurred in nine patients. Gastrointestinal symptoms were reported in five patients and central nervous system symptoms (headache, dizziness, or depression) in four; treatment had to be discontinued for side effects in three women. We conclude from this study that minocycline in the dosage used is an effective and well tolerated treatment for infection of the lower genital tract with *C trachomatis* in women, and the simple regimen is attractive.

Yours faithfully,  
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#### TO THE EDITOR *Genitourinary Medicine*

#### Colposcopy in genitourinary medicine clinics

Sir,

We write to inform colleagues of the results of our recent questionnaire regarding colposcopy service in genitourinary medicine in this country.

All consultants on the "Department of Health List of Genitourinary Clinics, 1985" were circulated. There were 105 consultants who replied who worked at 142 clinics. Of this number 35 had trained or were experienced in colposcopy, and 33 other members of clinic staff (13 senior registrars, 6 registrars, 3 senior house officers, 10 clinical assistants, and 1 associate specialist) were training in the use of the instrument. Sixty other consultants expressed an interest in training. There seem to be 42 colposcopes in use in these clinics, all but three of which are used regularly. The range of clinical investigation for which these instruments were used was extremely wide and included examination of the rectum, vulva, vagina, and cervix and most forms of pathology therein. Fifteen consultants used colposcopically directed biopsy of the cervix or vagina, or both. Three practitioners regularly use a laser for the treatment of cervical warts or cervical intraepithelial neoplasia, or both, and most of the rest use either cryosurgery or podophyllin, and a few use trichloroacetic acid for warts on the cervix. Fourteen respondents regarded colposcopy as not being useful in departments of genitourinary medicine, but

12 of these regarded the length of time taken for examination as being incompatible with the most economic use of their time (six of them were content to leave abnormal cytology to their gynaecological colleagues). Only two of these 14 replies stated that colposcopy was contraindicated in departments because of the risk of cervical bleeding associated with biopsy. Fourteen consultants were members of the British Society of Colposcopy and Cervical Pathology (BSCCP), with 40 expressing interest in becoming members and all these have since been circulated with details. Eighty respondents felt that joint scientific meetings between the BSCCP and the Medical Society for the Study of Venereal Diseases (MSSVD) would be valuable.

It seems, therefore, that colposcopy is enjoying a healthy prospect in genitourinary medicine, and junior staff are training to develop their skills.

We would like to see formal requirements for training in this skill recognised by our Specialist Advisory Committee for accreditation.

The provision of resources to continue developing colposcopy services in our speciality should be given a clear priority so that "routine" genitourinary patients are not denied access to clinics where colposcopy is performed. Where better to begin the investigation and treatment of abnormal cytology than in the clinics to which "at risk" patients present themselves and where such cytology is disproportionately to be found?

As the relations between wart virus subtypes, other possible infections, and non-infectious cofactors, and the progression of dysplasia are far from clear, where better to investigate these than in departments of genitourinary medicine? Moreover, the colposcope's potential in visualising non-dysplastic conditions and lesions at other sites is only beginning to be developed.

A harmonious relationship seems to be present between individual experienced genitourinary physicians and gynaecological colleagues, which is reflected in the common interest in the instrument and patient sharing. We understand that this co-operation is evident in more formal terms, as the BSCCP has approached the MSSVD to further detailed discussions and develop training courses designed for genitourinary staff.

We would value the comments of our colleagues.

Yours faithfully,  
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